Submitted Electronically

The Honorable Abigail Slater
Assistant Attorney General
Anticompetitive Regulations Task Force
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530

May 27, 2025

Re: Anticompetitive Regulations Task Force Request for Information (Non-Rulemaking Docket ATR-2025-0001)

Dear Assistant Attorney General Slater and Task Force Members:

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers, LeadingAge is pleased to provide feedback to the Department of Justice Anticompetitive Regulations Task Force ("Task Force"), in response to your call for comments concerning laws and regulations that undermine free market competition and harm consumers, workers, and businesses.[1] Our members serve older adults across the country and along a full spectrum of services and supports, such as affordable senior housing, assisted living and memory care, skilled nursing, home health, and hospice, and life plan communities that offer a continuum of housing and services to their residents.

LeadingAge specifically wishes to highlight the negative, anticompetitive impacts we are seeing play out daily as Medicare Advantage (MA) plans now have an outsized influence in the delivery of Medicare services. Our comments outline the ways in which plans hinder competition in the health care market, including regulatory barriers that limit the ability of Programs of All Inclusive Care for the Elderly (PACE) to compete with these plans on an even playing field. We conclude with a recommendation relating to broader antitrust guidance.

MEDICARE ADVANTAGE MARKET DOMINANCE IMPAIRS PROVIDER COMPETITION AND ACCESS

On behalf of skilled nursing facilities (SNFs) and home health agencies (HHAs) across the country, we submit this response to express deep concern about the unchecked market dominance of large, national MA plans and the resulting harm to provider viability, competition, and beneficiary access to care. It is critical that these anticompetitive issues are addressed now, given some policymakers' interest in making MA the default enrollment option for all Medicare beneficiaries.

As of 2025, 56% of the national MA market is controlled by three insurers – UnitedHealth Group, Humana and CVS/Aetna.[2] Importantly, one or two MA organizations in many counties dominate those local marketplaces, effectively limiting competition. Couple the market dominance with the fact that the traditional Medicare market continues to lose ground to MA, providers are faced with an imbalance of power. Unchecked, this dominance will only gain ground, as the large national plans are able to squeeze

[1] Justice Department Launches Anticompetitive Regulations Task Force (May 27, 2025)
[2] KFF: Medicare Advantage 2025 Spotlight: A First Look at Plan Offerings (Nov. 15, 2024)

out other smaller plan providers who can't compete with their available capital. In 2025, only three new insurers entered the MA market, while eight exited, demonstrating the challenges of participating in a concentrated market.[3]

The three dominant plans also are vertically integrated – owning or controlling other pieces of the health care system such as provider groups, pharmacy benefit managers, care management companies, and health care data and analytics companies – which further entrenches their market power limiting both consumer and provider choice.

1. Market Dominance and Anticompetitive Practices

Antitrust laws, including the Sherman Act and Clayton Act, are designed to prevent monopolistic behavior and ensure a competitive marketplace. However, in the MA space, these protections are being undermined:

- UnitedHealth Group (UHG) controls approximately 28% of the national MA market (9.9 million Medicare beneficiaries) in 2025, and Humana follows at 18%, with significantly higher shares in certain counties. For example, in Arapahoe County, Colorado, UHG controls over 65% of MA enrollment. In such markets, providers are left with no viable alternative but to contract with UHG, even under unfavorable terms. In Miami Dade County, Florida, two plans – one owned by Anthem and the other by Humana – dominate with a 70% share of the market, and 80% of all Medicare beneficiaries in this market are enrolled in an MA plan. So, two plans make decisions for 56% of all Medicare beneficiaries in that market.

- Some MA plans also lead Accountable Care Organizations (ACOs) that enroll traditional Medicare beneficiaries. The combined number of Medicare beneficiaries enrolled in these two models – Medicare Advantage and ACOs – can create even greater market dominance. Again, UHG's Optum subsidiary is considered one of the largest ACO operators in the country operating in 20 states.[4]

- The three national, dominant plans – UHG, Human and CVS/Aetna – routinely pay providers only 50-80% of Medicare Fee-for-Service (FFS) rates, while simultaneously increasing administrative burdens through prior authorization requirements, appeals processes, and claims denials.

- Often the larger national plans bundle contracts across multiple lines of business (e.g., commercial, Medicaid, MA, Special Needs Plans), refusing to contract with providers who seek to negotiate only for Medicare services and, in turn, requiring providers to accept inadequate payments in one line of business in order to participate in another. This practice effectively forces providers into all-or-nothing agreements, further consolidating the plans' control.

  The following example may violate section 3 of the Clayton Act. Some Minnesota SNFs have reported being forced to accept a contract with an insurer for both the MA and Medicaid business lines so the provider can participate in the mandatory Medicaid managed care program. Had the nursing home provider refused to sign the contract, it would have prevented it from admitting older adults on Medicaid into their nursing home. The MA plan offered rates that were insufficient to cover the skilled nursing facility's costs for delivering the services. This plan practice suppresses

[3] Ibid.
[4] See https://www.optum.com/en/care/locations.html

provider choice, preventing a provider from negotiating fair rates due to market dominance. Providers nonetheless are reluctant to take legal action for fear of retribution. Government oversight of these practices is needed to preserve access to care and competition in the market.

2. Vertical Integration and Exclusive Dealing

Exclusive dealing arrangements are prohibited under antitrust law when they substantially lessen competition or create a monopoly. From this perspective, it is important to note that several large MA plans also own or control provider networks, creating conflicts of interest and anti-competitive referral patterns:

- Under the guise of utilization management, these plans delay or deny authorizations for services from independent providers while steering referrals to their own subsidiaries. For example, in Georgia, a physician referred a patient to a home health agency that was uniquely qualified to provide post-acute care services for the patient's condition. The agency submitted the required prior authorization request to the MA plan, but the plan delayed authorization while its own agency initiated care – an apparent violation of fair competition principles.

- UHG's Optum subsidiary is reportedly already the largest employer of physicians in the U.S. with control of more than 10% of physicians – and now is on the road to dominating the home health care market by acquiring another home health company, Amedisys, with its 300+ Medicare-certified home health locations operating in nearly 36 states and Washington, D.C., adding to its current portfolio acquired through LHC Group in 2023. It would also make it a hospice leader.[5] This acquisition should be closely scrutinized by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) for its potential impacts on beneficiary access to care and health care provider financial viability and ability to compete in their markets with vertically integrated plans.

3. Impact on Providers and Beneficiaries

The consequences of MA plan market dominance are severe:

- SNFs and HHAs are being driven out of the market, particularly in regions where one or two plans control over 50% of MA enrollment. According to CLA's 39th SNF Cost Comparison and Industry Trends Report: "Since 2020, 774 nursing homes have closed, resulting in the loss of 62,567 beds and displacing 28,421 residents."[6] The report also notes: "The expansion of MA plans, which reimburse at lower rates than traditional Medicare, has reduced SNF revenue." The report shows that more than 49% of SNFs have negative operating margins. Similarly, one analysis shows, for HHAs in 2022 the all-payer margins across government and non-government payers was -2.1% and further that MA margins were -47.11%.[7] As MA's influence grows, its persistent underpayment of health care providers has the potential to create a financial death spiral for providers as a greater portion of their Medicare revenue is derived from MA, under plan contracts that don't cover provider costs.

- Providers are unable to sustain operations under below-cost reimbursement and excessive administrative overhead, leading to closures and reduced access to care. Premier, Inc. reported in

[5] Home Healthcare News: Exploring What an Amedisys Divestment Strategy Could Look Like (April 11, 2024)
[6] CLA Releases 39th SNF Cost Comparison and Industry Trends Report (Oct. 10, 2024)
[7] Project Sword: A MedPAC Rebuttal (July 30, 2024), as reported in Home Health News.

2025 that "healthcare providers spent an estimated $25.7 billion in 2023 contesting insurers' claims denials." Premier estimates that providers spent $18 billion "arguing over claims that should have been paid at the time of submission," as 70% of denied claims were ultimately overturned and paid.[8]

SNFs and HHAs are subject to relentless post-payment reviews, with one LeadingAge provider member describing a three-foot stack of partial or fully denied claims for which its staff must now re-submit supporting documentation, with plans sometimes requesting this documentation as much as three to four years after the original claim was paid. Providers may abandon these claims because they lack resources to defend them and are subject to recoupments. One large national MA plan is known across the country by providers as conducting these post-payment reviews for nearly every claim. Some providers are beginning to refuse to contract with that plan where they are able, because of the additional costs that the plan practices impose.

- Beneficiaries face delays in care, limited provider choice, and reduced quality, especially in rural and underserved areas. The Senate issued a 2024 report entitled "Refusal of Recovery" that outlines insurer abuses in denying and delaying post-acute care (PAC) services at astronomically higher rates than all other services.[9] The report is based upon 2019-2022 data and internal plan meeting notes and presentations provided by the top three national plans that demonstrate that post-acute care service denials are driven by plans' pursuit of financial gain, not the lack of medical necessity. It shows that these three plans denied PAC services at three times the rate of all other services requiring prior authorization. Humana was the most egregious, denying 24.6% of PAC prior authorization requests.

4. Policy Recommendations

To restore competition and protect access to care, we urge the Task Force and relevant federal agencies to consider the following actions.

A. Antitrust Enforcement and Market Oversight

- Conduct a market share analysis of MA plans at the county and regional level to identify areas where a single plan controls more than 40% of enrollment or where enrollment is concentrated in two or fewer plans.

- Investigate exclusive dealing and vertical integration practices under the Sherman and Clayton Acts, particularly where plans own provider networks and steer referrals.

- Prohibit MA plans from compelling providers to enter bundled contracts encompassing all lines of business as a condition of participating in any single line of business, such as Medicare Advantage or Medicaid.

[8] Premier Inc. analysis of MA burden on providers (Feb. 24, 2025)
[9] U.S. Senate Permanent Subcommittee on Investigations, Majority Staff Report: Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-acute Care (Oct. 17, 2024)

- Provide closer scrutiny of mergers and acquisitions in the MA space examining current market dominance both nationally and locally (county-level), consumer complaints and compliance issues, and control of providers.

B. Regulatory Reform

Recommendation: Prohibit Mandatory All-Lines Contracting by Health Plans

We recommend that the federal government establish a rule or enact legislation that prohibits health plans from requiring providers to enter contracts that span all or most of the insurer's lines of business (e.g., Medicare Advantage, Medicaid managed care, commercial insurance, etc.) as a condition of participation in any one program.

Providers must retain the right to contract selectively – for example, to participate only in Medicare Advantage or Medicaid managed care – without being compelled to accept terms for unrelated lines of business.

- Health plans may offer consolidated contracts for administrative efficiency, but providers must have the option to negotiate and sign contracts for individual lines of business without penalty or exclusion.

We further recommend that DOJ, in coordination with the Centers for Medicare & Medicaid Services (CMS), establish a clear enforcement framework that includes:

- Monitoring and auditing of plan contracting practices,
- Penalties for noncompliance, including civil monetary fines and potential exclusion from federal programs, and
- A confidential provider complaint process to report coercive contracting behavior with whistleblower-like protections.

This policy would help restore fair market dynamics, protect provider autonomy, and ensure that participation in one public program is not used to coerce acceptance of unfavorable terms in another.

Recommendation: Repeal the Medicare Advantage "non-interference clause" in Section 1854(6)(B)(iii) of the Social Security Act

LeadingAge recommends that Congress repeal the Medicare Advantage "non-interference clause,"[10] which says it is designed to promote competition but instead constrains CMS from carrying out one of its core functions of ensuring access to quality health care services for all Americans.

[10] Section 1854(6)(B)(iii) of the Social Security Act reads, "NONINTERFERENCE.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part."

The non-interference clause prevents CMS from: (i) setting minimum reimbursement rates that MA plans must pay providers to ensure their financial viability; (ii) requiring MA plans to include high-quality providers in their networks; and (iii) establishing value-based contracting standards and incentives.

We also recommend establishing limits on MA plan enrollment concentration, such that no single plan may enroll more than 50% of Medicare beneficiaries in a given market, including through affiliated Accountable Care Organizations (ACOs) or ACO REACH entities.

C. Transparency and Accountability

Recommendations:

- Require MA plans to report data to CMS on payments made to providers, payments denied, and post-payment review recoupments, along with any other data needed to assess the adequacy of MA plan payments to providers relative to Medicare FFS and disclose ownership relationships with providers. Subsequently, MedPAC should conduct an annual analysis of MA provider payment adequacy utilizing this and other available data and report its findings to Congress.

- Mandate timely and transparent prior authorization processes, with penalties for delays that result in care disruption.

The current structure of the Medicare Advantage market allows a few dominant plans to exert disproportionate control over provider networks, reimbursement, and patient access. Without intervention, this trend will continue to erode the viability of SNFs, HHAs and other providers, reduce competition, and harm Medicare beneficiaries. We urge DOJ to act decisively to enforce antitrust protections and restore balance to the Medicare Advantage program.

REGULATORY BARRIERS LIMIT PACE COMPETITION WITH OTHER INSURERS

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive and integrated full risk model of care and services for individuals over age 55. Many enrollees are dually eligible for Medicare and Medicaid, while meeting clinical eligibility to receive long-term services and supports. Providers of PACE services or PACE Organizations (POs) are fully financially responsible, via capitation payments, for all healthcare and long-term care needs of their enrollees. For the population served by PACE, their needs and clinical complexity are extensive.

LeadingAge contends that there are existing regulatory barriers that limit PACE competition among other available insurers, despite PACE programs having a significantly greater level of service and financial integration. LeadingAge has shared this feedback with the Office of Management and Budget, and we believe it is valuable to share with the Task Force as well.

1. Effective Date of Enrollment (42 CFR 460.158)

LeadingAge requests the elimination of regulatory limitations on programmatic enrollment to the first day of the subsequent month.

This regulation unnecessarily requires the PACE enrollment date to be the first of the month, but the enrollment date could be included in the participant enrollment agreement. CMS could easily determine a way to pay providers on partial month capitation regimens as it does in all other programs. Because someone is only eligible for PACE when they meet the clinical eligibility criteria for a nursing home,

limiting PACE enrollment to the first of the month is a barrier to accessing life-saving services. Medicaid long-term care (LTC) eligibility is not limited to the first day of the subsequent month; individuals eligible for PACE have been determined to meet the same needs-based threshold and are also most often eligible for Medicaid LTC.

This outdated rule puts the wellbeing of people with notable physical or cognitive limitations in jeopardy and can cause significant health decline before a PACE program is allowed take the person in on the first of the next month. The rule then translates into unnecessary spending on preventable deterioration, because the diagnoses of people delayed enrollment then contribute to PACE organizations' Risk 12 Adjustments, resulting in higher payments. Risk adjustments are used to establish and change rates paid to PACE programs based on the anticipated medical needs of the population being served. This offsets the costs to PACE organizations but could have been avoided both by the PACE organization and CMS if the person were able to be admitted at the time they found out about the program and were deemed to be eligible.

2. PACE Marketing Restrictions (42 CFR 460.82(e)(5))

LeadingAge requests the elimination of provisions that limit the ability of PACE organizations to engage in direct marketing.

The CMS provision that limits the ability of PACE organizations to engage in direct marketing is strongly worded and can be construed to mean that no unsolicited marketing is allowed. This provision should be completely eliminated.

Other limitations on PACE marketing, including related to the extent of services, enrollment procedures, and approval by CMS of all materials, ensure that when marketing is communicated to PACE-eligible individuals they will not be misled.

PACE is a program uniquely customized for dual eligibles, but current marketing restrictions prevent PACE organizations from directly promoting their services. This places both PACE programs and dual eligible beneficiaries at a disadvantage when evaluating Medicare options. Unlike MA and Special Needs Plans, PACE programs are not listed on the Medicare Plan Finder, and Medicare plan brokers often lack sufficient knowledge about how PACE compares to MA-only or Special Needs Plans. As a result, Medicare beneficiaries who could benefit from PACE are not fully informed of all their options, since PACE programs are restricted from direct marketing.

3. Limitations on Predatory MA Marketing Practices

CMS has acknowledged necessary action via proposed rule to curb predatory marketing by Medicare Advantage (MA) plans in the Contract Year (CY) 2026 MA, PACE, and Part D Proposed Rule. Within the rule, CMS takes aim at beneficiary safeguards and limits the use of inducements by MA plans in the form of flex or supplemental benefits that can be used similar to cash. We urge the task force to recommend CMS codify these protections to protect enrollees from uninformed decisions and unstable benefit elections as the value of these benefits can change without beneficiary notice.

PROVIDERS WOULD BENEFIT FROM REISSUED ANTITRUST GUIDANCE

In December 2024, DOJ and FTC jointly withdrew the 2000 Antitrust Guidelines for Collaborations Among Competitors, which followed the withdrawal in 2023 of the joint 1996 Health Care Enforcement Policy Statements.

Care networks in which organizations partner or consolidate to achieve clinical and financial integration are a valuable part of the healthcare landscape, serving the universal goals of reducing costs and improving quality, including management of transitions from one care setting to another (e.g. acute care to post-acute care) or from post-acute care to home. Many aging services providers have formed or joined such networks, and many more would welcome the opportunity.

For many years the agencies' joint guidelines offered a critical framework for assessing the legality of competitor collaborations, including joint ventures and information sharing, and provided valuable "safety zones" that helped organizations more confidently navigate antitrust laws.

We respectfully urge the DOJ and FTC to reissue updated Antitrust Guidelines that reflect current market dynamics while restoring clarity and consistency in enforcement expectations. Transparent guidance will support lawful innovation, cooperation, and competition across industries, and offer aging services providers flexibility to pursue strategic opportunities and partnerships, as they strive to innovate and strengthen access to high-quality, cost-effective care.

Conclusion

With the exponential growth in enrollment in recent years, MA is now the dominant payer for Medicare services, and three national plans control most of this activity while also owning or controlling other components of the health care system. It is critical to address the anticompetitive results of this market dominance that is creating barriers to new entrants, squeezing providers' financially and limiting consumer choice.

LeadingAge appreciates the opportunity to share our perspective, and we welcome the opportunity to engage with you further. Thank you for your consideration, and please contact me (nfallon@leadingage.org) if we can answer any questions or provide additional information.

Sincerely,

Nicole O. Fallon

Nicole O. Fallon
Vice President, Integrated Services & Managed Care

***About LeadingAge**: We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and thirty-six partners in forty-one states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.*